CHESAPEAKE EYE PHYSICIANS, PLC

Patient Registration and Medical Review/History Form

PATIENT INFORMATION:

NAME: _____
LAST FIRST MIDDLE INITIAL

ADDRESS: _____
STREET CITY STATE ZIP CODE

STATUS: MALE / FEMALE ___ SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED ___ SEPARATED

DATE OF BIRTH: _____ /_____ /_____ AGE: _____ SSN: _____- _____- _____

HOME PHONE: (_____) _____ WORK PHONE: (_____) _____ EXT: _____

OCCUPATION: _____ EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

NEXT OF KIN: _____ RELATION: _____ PHONE: (_____)_____

IF THE PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

FATHER'S NAME: _____ SSN: _____ - _____- _____

EMPLOYER'S NAME: _____ WK PHONE: (_____) _____

MOTHER'S NAME: _____ SSN: _____ - _____ - _____

EMPLOYER'S NAME: _____ WK PHONE: (_____) _____

INSURANCE INFORMATION: (PLEASE PRESENT YOUR INSURANCE CARDS AND/OR VALID REFERRAL)

PRIMARY INSURANCE: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

SUBSCRIBER'S NAME: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER'S SSN: _____ - _____ - _____ SUBSCRIBER'S BIRTHDATE: _____ / _____ / _____

SECONDARY INSURANCE: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

SUBSCRIBER'S NAME: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER'S SSN: _____ - _____ - _____ SUBSCRIBER'S BIRTHDATE: _____ / _____ / _____

AUTHORIZATION FOR MEDICAL CARE AND NOTICE OF PRIVACY PRACTICES:

I here by authorize treatment to the patient by the physician and/or staff of Chesapeake Eye Physicians, PLC. I also authorize release of any medical information necessary to process the insurance and I authorize direct payment of all charges incurred, as well as attorney and collection fees of 33 1/3% should such action become necessary. By my signature, I also acknowledge that I have reviewed the Chesapeake Eye Physicians, PLC's Summary of Notice of Privacy Practices. (A copy of the privacy booklet is available upon request.)

SIGNATURE: _____ DATE: _____ **(over)**

FOR OFFICE USE ONLY:
REVIEWED BACK AND FRONT BY :_____ DATE: _____

MEDICAL REVIEW OF SYSTEMS AND SOCIAL HISTORY: (Please check all that currently apply.)

- ❑ Fever
- ❑ Weight loss
- ❑ Blurred vision
- ❑ Hearing loss
- ❑ Sore throat
- ❑ Cough
- ❑ Rapid heart beat
- ❑ Tobacco use
- ❑ Sinus congestion
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Heart burn/upset stomach
- ❑ Joint pain
- ❑ Frequent colds/infections
- ❑ Alcohol use
- ❑ Muscle aches
- ❑ Itching or rash
- ❑ Muscle weakness
- ❑ Dizziness
- ❑ Mood swings/depression
- ❑ Easy bruising/bleeding
- ❑ Headaches
- ❑ Other: _____

MEDICAL HISTORY: (Please check all that apply.)

Your Medical History:

- ❑ Diabetes
  Type I or II
  How Long? ____
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Arthritis
- ❑ Asthma or emphysema
- ❑ Chicken pox or shingles
- ❑ Congestive heart failure
- ❑ Depression
- ❑ Eye injuries/Surgery
  Type: _____
  Date: _____
- ❑ Heart attack
- ❑ Hepatitis
- ❑ High cholesterol
- ❑ HIV or AIDS
- ❑ Hypertension
- ❑ Irregular heart beat
- ❑ Lymphoma or leukemia
- ❑ Migraine
- ❑ Cancer or tumors
  Type: _____
  Date: _____
- ❑ Multiple sclerosis
- ❑ Poor circulation
- ❑ Seizure
- ❑ Stomach ulcers or gastritis
- ❑ Stroke
- ❑ Thyroid disorder
- ❑ Other: _____
- ❑ Other: _____

Family Medical History: (Blood relation only.)

- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Arthritis
- ❑ Asthma or emphysema
- ❑ Cancer or tumors
- ❑ Chicken pox or shingles
- ❑ Congestive heart failure
- ❑ Diabetes
- ❑ Depression
- ❑ Heart attack
- ❑ High cholesterol
- ❑ Hepatitis
- ❑ HIV or AIDS
- ❑ Hypertension
- ❑ Irregular heart beat
- ❑ Lymphoma or leukemia
- ❑ Migraine
- ❑ Multiple sclerosis
- ❑ Poor circulation
- ❑ Seizure
- ❑ Stomach ulcers or gastritis
- ❑ Stroke
- ❑ Thyroid disorder
- ❑ Other:_____

MEDICAL INFORMATION:

REASON FOR EXAMINATION: _____

MEDICATIONS: _____

_____

ALLERGIES TO MEDICATONS: _____

WHO REFERRED YOU TO OUR OFFICE?: _____

WHO IS YOUR MEDICAL DOCTOR?: _____ OFFICE PH: (____) _____

HOW DID YOU HEAR ABOUT US? ____ Newspaper ____ Mail ____ Doctor ____ Friend ____ OTHER, please specify

Information Regarding Additional Fees Which May Be Incurred During Your Examination

(Please read and initial each line)

_____The co-pay for your exam is an agreement between you and your insurance provider. Our doctors are specialists; therefore, the specialist co-pay will be collected on the day of your visit.

_____If your insurance requires a referral, it is your responsibility to ensure your Primary Care Physician provides a referral prior to your visit. If we do not have a referral upon check-in, you will be asked to sign a waiver stating your understanding of your financial responsibilities without a referral.

_____The refraction is not covered by most insurance policies, but is a necessary procedure in order to help evaluate the health of your eyes and determine your glasses prescription. It is the part of the exam where the technician puts a device, called a phoropter, in front of your eyes and asks, "which is better 1 or 2?" The cost of the refraction is $35.00. **It is the patient's responsibility the day of the exam.**

_____If you are a contact lens wearer, we are required by law to examine the contact lens fit every year, which includes measuring lens size, tear flow, base curve, and power. There is a fee for the contact lens evaluation, **starting** at $60.00, which is separate from the office visit, refraction fee, and your insurance co-pay. Should any problems with the comfort or vision of your contact lenses arise, please visit our office within 90 days of your exam to avoid additional fitting fees.

_____For the safety and health of your eyes, a training session will be scheduled with our opticians to go over insertion, removal and proper care of contact lenses for all **new** contact lens wearers. The fee for this training is $65 and is required prior to releasing contact lens prescriptions to new wearers.

_____There is a $25 fee for no-show appointments that are not cancelled 24 hours in advance.

_____There is a fee for completing forms and testing required for DMV, Disability, FMLA, etc. These fees range from $25-$80. Your insurance will not cover these fees and they are due upon form completion.

_____Vision Plans: If you have a vision plan, it is your responsibility to notify the front office staff, the technician and the doctor that you are here for a routine vision exam under your vision plan or vision benefit. Please understand that vision exams are for routine vision problems (e.g. near or far sighted vision) not for medical conditions. If you have a medical eye condition known or discovered at this "routine vision" exam, you may be asked to make another appointment to be examined for this medical condition. We cannot file claims to both your Vision Insurance and your Medical insurance on the same day. If you do not notify prior to the visit that this exam is for a "routine vision exam" and there is a medical condition, we will file your medical insurance. We will not go back and file this visit under your Vision plan even if your medical insurance paid nothing or applied the fee to your deductible. **You must let us know prior to the exam which plan this claim is to be filed.**

The purpose of this notice is to ensure our patients have a complete understanding of possible charges to avoid any "surprise" fees. Please be aware that the refraction fee, contact lens evaluation fee, contact training fee and insurance co-pay are all separate fees that may not be covered by your insurance. **These fees are all due the day of your examination.** By signing below, you acknowledge and agree to the above terms and conditions for Chesapeake Eye Physicians, PLC.

Thank you in advance for your cooperation.

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